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**AUTHORIZATION FOR USE OF FIRST-CLASS OR PREMIUM-CLASS  
OTHER THAN FIRST-CLASS (PCotFC) TRAVEL ACCOMMODATIONS**

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**FOR EMPLOYEES WITH DISABILITIES OR OTHER SPECIAL NEEDS**

First-Class<sup>1</sup>

☐

PCotFC

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(Please check authorization requested)

NAME OF EMPLOYEE:

\_\_\_\_\_

ORGANIZATION:

\_\_\_\_\_

NATURE OF DISABILITY OR SPECIAL NEED:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CERTIFICATION: I CERTIFY THAT I AM DISABLED OR OTHERWISE REQUIRE SPECIAL NEEDS  
SUCH THAT OTHER THAN FIRST-CLASS/PCotFC ACCOMMODATIONS CANNOT BE USED.

SIGNATURE OF EMPLOYEE:

\_\_\_\_\_

SIGNATURE OF COMPETENT MEDICAL AUTHORITY:

\_\_\_\_\_

AUTHORIZED BY:

\_\_\_\_\_

TITLE:

\_\_\_\_\_

DATE:

\_\_\_\_\_

THIS AUTHORITY WILL EXPIRE AT EITHER SIX OR TWELVE MONTHS FROM DATE OF  
APPROVAL DEPENDING UPON NATURE OF DISABILITY OR SPECIAL NEED (See NIH MANUAL  
1500 CHAPTER 13-00 (D) (1)).

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<sup>1</sup> If First-Class accommodations are requested, please provide specific medical reason why PCotFC accommodations cannot be used. If no reason is given, only PCotFC will be authorized.